First Year/New Member VCMS Physician Membership Application

Please Return Application and Membership Dues to Volusia County Medical Society,
P.O. Box 9595, Daytona Beach, FL 32120-9595 (386) 255-3321

PERSONAL INFORMATION (please print or type)

_____ ☐ MD ☐ DO
Last Name First Middle Initial

FL Medical License #: _____

Practice/Group Name:_____Practice Manager Name:_____

Practice Type: ☐ Solo ☐ Group ☐ Employed ☐ Government Based ☐ Academic ☐ Other

Primary Specialty: _____Secondary Specialty: _____

MAILING INFORMATION – PLEASE PROVIDE BOTH ADDRESSES

May we provide your home address/cell phone number to other VCMS members? Yes No
Personal information is never given out to any 3rd party vendors.

_____
Office Address Home Address

_____
Office City/State/Zip Home City/State/Zip

_____
Office Phone Home Phone

_____
Office FAX Cell Phone

_____
Email Address Email Address

_____
Website

EDUCATION	**Institution**	**Location**	**Degree**	**Dates**
Medical School:				
Residency				
Fellowship				
Other Post Graduate				

BOARD CERTIFICATIONS		**Date Certified**		**Date Recertified**	
Name of Board	**Certified in**	**Year**	**Month**	**Year**	**Month**

HOSPITAL AFFILIATIONS	
Hospital	**Full Address**

Do you wish the VCMS to refer patients to you? _____Yes _____No

OVER

Have you ever been convicted of a felony or misdemeanor, or held for violation of Federal or State narcotic laws; or the illegal use or sale of drugs?

Yes No

☐ ☐ (If yes, please provide full information.)

Has your license to practice medicine in any jurisdiction ever been limited, suspended or revoked?

Yes No

☐ ☐

Have any disciplinary actions ever been taken regarding your hospital privileges or medical society membership?

Yes No

☐ ☐

By my signature, I agree to accept and be bound by the Articles of Incorporation and Bylaws of the Association, and the Principles of Medical Ethics of the AMA, together with all future amendments of such Articles of Incorporation, Bylaws or Principles of Medical Ethics which may be duly adopted by the respective organizations.

I hereby release and hold harmless from any liability or loss, the medical society, their officers, agents, employees, and members for acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and hereby release from any liability any and all individuals and organizations, who, in good faith and without malice, provide information to the above-named organizations, or to their authorized representatives, concerning my professional competence, ethical conduct, character, and other qualifications for membership. I understand that any false or misleading statement(s) made on my application may be grounds for denial of membership, or probation or censure by, or suspension or expulsion from, the society. By signing this agreement I give VCMS permission to use my name and/or likeness for promotional purposes.

I hereby certify that the foregoing is true and correct to the best of my knowledge. I understand and agree that if I knowingly made a false representation in this application or a representation that in the exercise of reasonable care I should have known to be false, the medical society has the authority to reject this application.

Signature _____ Date _____

BIOGRAPHICAL RECORD FOR VCMS ARCHIVES

Spouse: Name_____(used for invitations, special event notification, etc.) Would s/he like to be included in the weekly e-letter, The Connections Newsletter? If so, please provide his/her email address:

Professional Work with Specialty
(please attach additional pages if required):

Places _____
Dates with Title _____
Honors _____
Offices _____ Appointments_____

Hospital Staff:

Membership _____
Dates & Offices _____
Appointments _____
Professional Organizations _____
Titles _____
Offices with Dates _____

Military:

Ranks & Dates _____

IMPORTANT: Once received, your application will be presented to the Membership and Executive Committees. **With your completed application include a copy of your Florida Driver's License, a copy of your Florida Medical License, at least one (1) letter of reference from a licensed physician and a check in the amount of your annual membership dues. First year's annual dues at $200 discounted rate apply.** Annual dues may also be paid online @ www.vcms.org. **Forward an electronic file of a recent photograph** (.jpg may be emailed to vcmedsociety@gmail.com). If for any reason your application is not accepted for membership, your annual membership dues will be promptly refunded.

Please Return Application, including required documents and dues as noted above to:
Volusia County Medical Society, P.O. Box 9595, Daytona Beach, FL 32120-9595
***(386) 255-3321* Website: www.vcms.org**